Appendix two – BCF scheme aims

Scheme name	Aims
1. Care home assessments at the weekend (iBCF)	• Work has been undertaken with the care home sector to ensure that any individual who is fit for discharge over the weekend period can be assessed and returned to their care home. This will form part of our contracts with care homes. This meets the requirements of the 'High Impact Change Model' for managing Transfers of Care in particular seven day working and reducing the pressure on the NHS.
2. Care Package retention of 7 days	• Cheshire East Council have an agreement with extra care housing schemes and Dom care providers to pay a retainer to the care provider in order to keep the care provision open whilst the individual is absent for a period of time, e.g., in hospital. The retainer ensures that individual's existing care provider is kept available for a period of up to 7 days to resume the existing care package when the person is fit or ready to return home. If the person is in hospital this should facilitate a timelier/appropriate discharge.
3. Innovation and Transformation Fund	• In order to support the 'Caring Together' and 'Connecting Care' transformation plans. Cheshire East Council will create a fund that the NHS and partners can access to support initiatives that promote the move towards integrated working (community teams) to achieve better outcomes for the residents of Cheshire East. • NHS Eastern Cheshire CCG - This forms part of the work to implement assessment and care outside of hospital as appropriate. There is the need for a range of options and discharge destinations to ensure that wherever possible people are supported to remain at, or return to, their usual place of residence - 'Home First'. The elements of the Winter Plan for 2017/18 are: • Flexible capacity to match different needs of patients reviewed throughout winter • Implement the Caring Together model through the 'Home First Winter Plan' developments • Integrate and connect care and services wherever possible based on a person-centred journey • Co-production - through a joint commissioner/ provider 'action group' to implement and manage • Identify, manage and escalate risks e.g. a lack of beds/staffing capacity to implement initiatives • Support Care Homes to ensure their sustainability The additional/enhanced interventions we will deliver are targeted towards: • People currently living independently who experience a sudden change in their needs • People who are already in receipt of existing care in response to an escalation of their needs • Frequent callers/attenders (A&E, GP Practices, NWAS, Social Care) iBCF funded Home First Winter Plan Services delivering these aims: • Rapid Return Home (Overnight) Service • Care Home Support • Flexible non-acute bed capacity/Discharge to Assess Beds • Increased support for community Matrons case-managing High Risk patients. NHS South Cheshire CCG Schemes • Increased Rapid Care Support • Clinical Support to care Homes

	• Dedicated Support for D2A Implementation
4. Funding for additional social care staff to support Discharge to Assess initiatives (iBCF)	• Funding of additional staff to support the local transformation programmes Caring Together and Connecting Care in implementing a 'Discharge to Assess' model. This builds on the existing initiative with Eastern Cheshire where funding is being targeted at continuing to provide a team manager, social worker and occupational therapist, plus the roll out across Mid-Cheshire.
5. Increasing capacity in the Care Sourcing and Social Work Team over Bank Holidays and weekends (iBCF)	• This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven day period.
6. Sustain the capacity, capability and quality within the social care market place (iBCF)	• In order to sustain and stabilise both the domiciliary care markets and care home markets. This means transforming the care and support offer to ensure Cheshire East has greater capacity and an improved range of services. Local partners will jointly commission the new offer and include: Discharge to Assess beds, step up/step down beds, more specialist provision for complex needs and care at home services that promote quality of care under the system beds programme.
7. The use of Live Well online information and advice resource (iBCF)	• Cheshire East Council has embarked on a programme to deliver a new online resource to the public: Live Well Cheshire East. Both Clinical Commissioning Groups have expressed a desire to utilise this platform and expand the offer to create a community infrastructure that maps all existing assets for use of professional staff alongside members of the public
8. Assistive Technology	• Reduce the demand on health and social care services over the longer term by ensuring access to assistive technology and telecare solutions to people with eligible needs to maintain independence in a community setting. • Increase the independence of people living with long term conditions and complex care • Support for carers to maintain their caring role. • Improved access to the right service at the right time is the overall aim of this scheme.
9. Carers Breaks / Integrated Carers Hub	• The aim of the scheme is during 2017/18 to replace the current carers breaks provision with the Carers Living Well Fund.
10. Disabled Facilities Grants	• The Disabled Facilities Grant (DFG) contributes to preventing non-elective admissions and DTOC in Cheshire East through the provision of adaptations that enable independence at home, and reduce falls and the risk of injury to disabled people and their carers. It is anticipated that 800 people will benefit from adaptations to their home over the period of the BCF plan.
11. Home First (NHS Eastern Cheshire CCG)	1. Proactive care: • Risk stratification of the population is enabling services to be targeted to the people who need them most. It identifies the top 20% of the population who are most at risk of experiencing poor health and empower them to live more independently. We are currently targeting top 5% and working towards 20%. • These people will receive a single assessment focused on their lifestyle, goals and care needs using a joint assessment across

	health and social care • For those most at risk, a care co-ordinator will be identified from within an integrated community team • A care plan will be created jointly with the person to include goals, required interventions, provider details, and information on who to contact in case of change or crisis. For less complex needs, this may simply be a crisis plan • Services are being put in place to empower the person and their carers and meet their needs. The integrated community team and care co-ordinator (as appropriate) will then undertake case management to empower the person to follow the care plan and make sure that care takes place • Specialists will provide support in the community for professional care staff and patients • Education and training will be delivered across all care settings and involve the whole workforce in a rolling evidence-based training and mentoring programme. • Services already in place supporting this which are included in BCF: Nursing Home MDT staff (Dietician and Speech and Language Therapist); NIMO medicines support; Community Matrons case-managing highest risk and frail patients; Telehealth 2. Rapid Response in Crisis and Management of the Patient Journey • Comprehensive assessment on attendance at A&E or Admission to Acute Assessment Unit (Frailty Service) . Turn patients around prior to admission and if not possible, minimise inpatient stay (Home First). Link to existing care plans via Cheshire Care Record and live access to Primary, Community and Social Care records as appropriate. • Schemes to enable rapid return home via increased nursing and therapy support to A&E and outreach into community. • Schemes to enable rapid return home by providing transport and "settling back home". • Comprehensive bed-based service for patients able to be discharged from acute setting or requiring temporary step-up of care. • Community intermediate care to enable recovery at home. • In-hours GP visiting service for End of Life patients enabling timely access and increasing number of deaths in preferred place. • Services already in place supporting this which are included in BCF: Intermediate Care Beds and community service; additional evening staffing in A&E; Therapy support at front end; Transport home from A&E at night; Acute Visiting Service (3 GP teams).
12. Home First (NHS South Cheshire CCG)	• Develop system wide service review to enable rapid timely access to urgent care across Central Cheshire that will bring together existing service providers together to shift the balance from acute bed based services to community step up and home based health and social care to support improved patient outcomes and experience. • Review existing models of intermediate care and social care reablement that create system wide efficiencies through single assessment and increase capacity to support more people closer to home and reduce duplication of assessments with demonstrable improved outcomes in relation to reduce the length of stay in acute care and emergency department attendances that also demonstrate value for money. • Explore and identify opportunities to work in collaboration with the wider health and social care economy, such as voluntary sector, pharmacy services and primary care to create more of an emphasis on enablement and self-empowerment to meet health and social care needs. • Scope the potential financial impact on reducing emergency admissions as part of the redesign, with greater emphasis on medical responsibility being maintained in primary care, with support from specialist services. • Streamline the assessment process of patients that supports safe transfer of care and improves patient experience, utilising a comprehensive geriatric assessment to outline future management plans and reduce the risk of readmission or long term care

	placement. There is a need to quantify potential impact on readmission rates and CHC reduction costs based on national data if possible • Target a reduction in delays in transfers of health and social care with the development of the trusted assessor framework. • Develop a discharge to assess model that improves timely discharge from acute care of frail older people to their normal place of residence as soon as the acute treatment is complete with an assessment that have agreed personalised goals agreed in conjunction with the person and carers. • Improve utilisation of commissioned community bed stock to meet patient need rather than service need.
13. Support at Home Service – (British Red Cross to provide practical and emotional support at home over 7 days) NHS Eastern Cheshire CCG	• The aim of the service is to provide short-term (up to 2-weeks) support over 7 days for individuals who are at risk of being admitted to hospital and for people who are being discharged from hospital in the Cheshire East area. • This support should provide practical and emotional support for individuals to help them to regain their confidence, maintain their confidence and avoid any future crisis, with a focus on enabling a person to become confident in self-management, or know how to access support and information, if required, to help them keep well.
14. Programme Enablers	• To provide enabling support to the Better Care Fund programme, through programme management and other support, as required • To develop and maintain adherence to governance arrangements including the s75 agreement and commissioning capacity • The delivery of the Better Care Fund relies on joint commissioning plans already developed across the Cheshire East Health and Social Care economy. it is recognised that additional capacity is required in the interim in the following key roles: • Programme management • Governance and finance support to develop S75 agreements; cost schemes and cost benefit analysis • Financial support • Additional commissioning capacity might be required to develop business cases and to assist with the procurement of alternative services.
15. Reablement Services	• The current service has three specialist elements delivered across two teams (North and South): • Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs. • Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia. • Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.
16. Care Act	• Ensure compliance with Care Act 2014 responsibilities. • Provider Quality Reports (BCF Social Care Act Allocation) • Safeguarding Adults Boards • Maintaining minimum care eligibility thresholds • Continuity of care for people moving into areas

	• Assessment of Social Care in prisons • Disregard for armed forces Guaranteed Minimum Income • Training social care staff in Social Care Act